Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SAN ANTONIO PAIN & REHAB CENTER
1007 POTEET JOURDANTON FWY STE 120
SAN ANTONIO TX 78224

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-5137-02

MFDR Date Received
August 16, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position summary was not provided in this dispute.

Amount in Dispute: $6,149.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pursuant to the DWC-24 signed on 6/3/10 resolved that the Claimant did sustain a compensable injury on 5/27/09 which extended to include a lumbar strain/sprain. The compensable injury was agreed to not extent [sic] to and include lumbar herniations, lumbar radiculopathy, lumbar myospasm, hip, or the right knee. Requestor's diagnoses for the treatment performed do not match the injury agreed upon. Therefore, Respondent's denial of the medical bills for extent of injury was accurate."

Response Submitted by: Downs♦Stanford PC; 2001 Bryan Street Suite 4000; Dallas TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 3, 2010 To March 19, 2010	99204-AQ, 99080-73, 99213-AQ 97110-GP-AQ, 97112-GP-AQ, 97530-GP-59, 97140-GP-AQ	$6,149.05	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305 relates to MDR – General.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 25, April 23, 2010 and June 23, 2010

- 218 - Based on entitlements to benefits
- 5110 – Service denied per claims examiner's instructions
- 193 - Original payment decision is being maintained. This claim was processed properly the first time

Explanation of benefits dated July 6, 2010

- W4 – No additional reimbursement allowed after review of appeal/reconsideration

Issues

1. Is the disputed service eligible for medical fee dispute resolution per 28 Texas Administrative Code §133.305 and §133.307?
2. Did the requestor treat the compensable lumbar sprain/strain and is the requestor entitled to reimbursement?

Findings

1. A Benefit Dispute Agreement (DWC-24) was signed on June 3, 2010 to resolve that the claimant sustained a compensable injury and extends to include a lumbar strain/sprain. The parties further agree the compensable injury does not extend to and include lumbar herniations, lumbar radiculopathy, lumbar myospasm, hip or the right knee. Therefore, the disputed services will be reviewed in accordance with applicable Division rules and fee guidelines.
2. According to the DWC-24, the agreed upon injury is a lumbar strain/sprain. The medical bills submitted by the requestor in this dispute were reviewed and contain the following diagnosis codes: 722.10-DISPLCMT LUMBAR INTERVERT DISC W/O MYELOPATHY; 724.4-THORACIC/LUMBOSACRAL NEURITIS/RADICULITIS; 728.9-UNSPECIFIED DISORDER OF MUSCLE LIGAMENT&FASC; and 717.0-OLD BUCKET HANDLE TEAR OF MEDIAL MENISCUS. The requestor did not submit any medical records for review; therefore, the Division cannot determine if the treatment rendered was for the compensable lumbar strain/sprain. As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	JUNE 26, 2012 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.